Transcript: Alcohol is STILL a Drug: An Exploratory Webinar Series

Presenter: Gabriela Zapata-Alma
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PRESENTER: Well, good morning those of you who are joining us. We are going to get started in just a couple of minutes. And wait for a few more folks-- many more folks to join us. And thanks for being here.

If you're just joining us, we will get started in just a minute or two. Trying to get folks connected, and then we'll get started. So I'm glad you could be here with us today.

I'm going to go ahead and get us started. I want to welcome you all to the seventh session in our Alcohol is Still a Drug series. This presentation is brought-- prepared and brought to you by the Great Lakes ATTC, MHTTC, and PTTC under a cooperative agreement from the Substance Abuse and Mental Health Services Administration.

The opinions expressed in this webinar are the views of the speakers and do not reflect the official position the Department of Health and Human Services. The ATTC, MHTTC, and PTTC believe that words matter and uses affirming language in all our activities.

Just a few housekeeping things if you're having any technical issues. Please individually message Jen Winslow or Rebecca Buller in the chat section and she or I will be happy to assist you. Please put any questions in the Q&A pod at the bottom of the screen. This helps us keep track. And we've talked with Gabriella and she will try to address a few of those questions at the very end.

We'll be using automated transcripts for today's webinar. And certificates of attendance will be sent out to all who attended the full session. They can take up to two weeks, and you will be sent a link to your certificate via email. Sometimes these things go into your spam. And so double-check there before you let us know if there's a problem. This presentation will be recorded and posted to our website within two weeks.

We always invite you to join us and learn more about what's happening in the PTTC networks, on our social media. And finally, I'd like to introduce our speaker. Gabriela Zapata-Alma is a licensed clinical social worker, and she is

the Associate Director at the National Center on Domestic Violence, Trauma, and Mental Health. Let's see, I want to just take a pause here. I'm trying to stop sharing.

All right. Gabriela bring this over 15 years of experience supporting people impacted by structural and interpersonal violence and their traumatic effects through evidence-based clinical, housing, resource advocacy, and HIV-specific integrated care programs.

Currently, Gabriela author's best practices, leads national capacity building efforts, and provides trauma-informed policy consultation to advance health equity and social justice. Welcome, Gabriela, and are you able yet to share your screen?

GABRIELA ZAPATA-ALMA: Yes. All right, let me bring that up. And then also, as I'm bringing that up, I want to just also say thank you so much for inviting me, for hosting me. Today it is such an honor to be here with everyone and I'm so glad that everyone is able to join.

And so talking about the intersections of domestic violence and alcohol. And here's just a little bit of information about the National Resource Center on Domestic Violence, Trauma, and Mental Health. And you can find a lot of different resources on our website.

So the intersection between alcohol use and domestic violence involves so much more than just alcohol use and domestic violence. Very often there are complex intersections that include sexual assault, mental

health, and trauma. So we're going to take some time and start to pull apart some of these complex connections.

First, being abused by an intimate partner can have adverse effects on our physical health, on our mental health, and on our relationship with alcohol. And domestic violence is very common amongst people who are seeking treatment. So here we have some different statistics from the available literature.

So that being victimized by an intimate partner increases our risk for PTSD, major depressive disorder, and self-harm. Three times higher risk there. A four times higher risk for suicide attempts and a six times higher risk for developing a diagnosable substance use disorder. And so there are really

high rates of experiencing domestic violence among women accessing substance use disorder treatment.

We know domestic violence impacts people of all genders and disproportionately impacts women. So specifically for women accessing substance use disorder treatment, there's anywhere from nearly 50% to 90% of women report experiencing this kind of abuse in their lifetime. And then when just looking at the past 12 months. This is anywhere from a third to two-thirds of women in treatment.

And that's something to keep in mind, because even if a person has been able to limit some of the danger, has been able to leave an abusive relationship, there is many times ongoing stalking and victimization and risk for ongoing assault. So looking at the intersection of substance use and victimization, alcohol use disorders are over four times higher in women who have a history of victimization, and very often what is being looked at here is physical violence, sexual violence.

So prior assault is a risk factor for developing an alcohol use disorder, and alcohol use is also a risk factor for increased targeting. Now here it's really important to be clear that alcohol use does not cause victimization, alcohol use does not cause violence, but that using alcohol can increase the targeting by somebody who is seeking to cause harm in these ways.

And that being abused by an intimate partner is usually not-- or abusing an intimate partner is usually not the first time that somebody is experiencing trauma in their lives. Sometimes it is, but many survivors, as well as many people who seek to exert power and harm over their intimate partners, have a lifetime experience of trauma, starting with adverse childhood experiences. A set of experiences that can be experienced within the home as well as an expanded ACEs in the broader community.

And so here, you see the different ACEs that have been studied at this point. Conventional ACEs include things like being abused, physically abused, emotionally abused, sexually abused, et cetera, neglect, as well as other aversive experiences within the household. And then on the community level, things like witnessing community violence, having a lack of neighborhood safety, experiencing racism, having an out-of-home placement through child-- through living in foster care, and experiences of bullying.

And so these are associated with an increased risk around a lot of global health dimensions that we experience in our life, including being abused by an intimate partner or abusing one's intimate partner. Now at the same time, it's

important to recognize that adverse childhood experiences, they tell us about risk factors. They don't tell us about protective factors.

And so as much attention as we place on adverse childhood experiences, We. Also equally or more so need to pay attention and invest in the protective factors that help mitigate. And here, sometimes these are called counter ACEs, sometimes these are called positive childhood experiences. And so there's a lot of ongoing research in this area, but there are four broad categories that have been proposed at this point.

So during childhood, the experience of being in nurturing supportive relationships. Living, developing, playing, and learning in safe, stable, protective, and equitable environments. So any environment that

children and families may have access to. Having opportunities for constructive social engagement and connectedness, as well as learning social and emotional competencies.

So thinking about in all of our programs, the importance of having multigenerational and family-based programming and how-- when we are thinking about ACEs, we also want to be thinking about how are our services supporting people in creating environments and relationships that counter ACEs?

And that we are also enhancing protective factors related to trauma. And there are four core protective factors. Social support, community. And so how are our services really building community within and then helping to integrate in the broader community? This really speaks to the power of safety and healing in our relational emotional service environments, as well as the power of peer support.

Positive connection with a caregiver. So something that I'll talk about a little more is how so often domestic violence seeks to really threaten parent child attachment with protective caregivers. And so looking at within our services, how are we really shoring up those connections with protective caregivers? Especially when we see intersections of different systems that can also lead to separation of parents and children.

Socioeconomic stability. So that vocational services and just overall resource advocacy is trauma prevention, is core to the work. And of course, access to medical and mental health care, and that includes all of our services. So in addition to the traumatic effects of domestic violence, less well-recognized are

the ways that people who abuse their partners engage in coercive tactics targeted towards a partner's mental health or use of substances.

So broadly, this is a form of domestic violence known as substance use coercion. And this can include a lot of different abuse tactics. But in general, these abusive tactics deliberately seek to undermine a partner's sanity and sobriety, to control a partner's access to treatment and recovery capital, to sabotage a partner's recovery efforts, discredit a partner with potential sources of protection and support, including jeopardizing child custody, and then to exploit a partner's substance use for personal gain or financial gain.

This data here comes from a study that we conducted in partnership with the National Domestic Violence Hotline where over 3,000 callers to the hotline who were not identified as having a history of substance use. They just were general callers who are not in time of the-- who are not in crisis at the time of their call and who consented to be a part of this research.

And of those general callers, 26% had used substances to deal with the pain of domestic violence, both physical and emotional pain. 27% had been pressured or forced to use substances or made to use more than they wanted. And we see this very commonly with alcohol, the sense of survivor needing to be pressured or coerced to drink more or to drink at all.

24% were afraid to call police because their partner said that they would be arrested or not believed because of their substance use. And most-- the substance most commonly used in this study, just as it is in the nation, was alcohol. And then 38%-- so nearly 40% of callers said that their partner had threatened to report their substance use to authorities to prevent them from getting something they wanted or needed. And very often this was an order of protection or custody of their children.

And of those callers who had tried to get any kind of help around their substance use, 60% who tried to get help said that their partner or ex-partner had tried to prevent them or discourage them from getting help. So we already know that the vast majority of people who have a diagnosable alcohol use disorder aren't accessing treatment. Something that we need to think about when we think about all the different reasons why people might not be accessing treatment is the presence of domestic violence.

So this came from that same study it was in a survivor's own words. "He threatened countless times to call the sheriff and the pastors and report my drinking. He discouraged me from getting help from my drinking. After I got help for drinking, if/when I drank again, he would say, 'See, you failed at this, too.' He would leave bottles all around when I was in recovery."

And so seeing here how the abuse tactics become really intertwined with the alcohol use, and then leverage the alcohol use in order to entrap survivor within that abusive relationship. So many of the tactics are not only aimed at introducing the alcohol use and then escalating the alcohol use to a point where we start seeing some physical dependence, withdrawal, start seeing some problems related to alcohol use such as driving under the influence, but then also will deliberately expose somebody to cues for cravings.

It's including presenting them with alcohol, leaving bottles around, as well as presenting them with things that they might associate with alcohol in order to deliberately increase cravings and try to sabotage a person's recovery.

So we need to think about our services, if our services are all cutting people off from resources, from support because of a setback in recovery, not only is that really delaying access to the help that's needed in order to address that alcohol use disorder, but additionally, we might be playing right into an abusive part-- or excuse me, right into that abuse. We might be playing right into the very abuse that is trying to sabotage that recovery.

And then very common, our research has found, very common to keep alcohol in the home, to have the active attempts to provoke setbacks in recovery. Also to try to influence care. To try to get somebody kicked out of treatment, to stop them at appointments, to threaten and intimidate them when they aren't accessing treatment.

Sometimes this shows up as someone who seems very concerned, and then they are calling with concern. Well, this person doesn't stop drinking and I'm really concerned, and then this leads to different-- them potentially getting kicked out of treatment. Or sometimes this comes up as like excessive texting, and then the person is maybe sitting in a group and they're texting back to this partner who they know that they'll face increased danger if they aren't texting back right away.

But then if providers aren't savvy to this, what they may think is, oh, well, this person isn't engaged in their treatment or this person is-- won't keep up with the group norm of putting their phone aside. And so we're not-- we're going to tell them they can't attend group. So thinking about all the ways that our different policies might actually play into cutting people off from treatment, when in fact, what they're experiencing is domestic violence.

Of course, not being allowed to attend recovery meetings or seek treatment. And then, many times things like withholding the resources that help

somebody that somebody really needs in order to engage in treatment as well as in their recovery. Things like withholding transportation, child care, and financial resources needed to engage in treatment and recovery.

So something that I did when I was a treatment director was made sure that we had grant funding to cover the cost of treatment for people who couldn't use their partner's insurance, or they couldn't use their insurance because then an explanation of benefits would be sent to their home and that would increase the danger. Or they didn't have access to the financial resources because of the economic abuse, and then we made sure to have those financial resources for people who couldn't use their household's financial resources.

Thinking about if somebody calls and says, my partner said that they'd be back with the car by now, but they're nowhere to be found. Do you have a service to help them engage? Is there a way either virtually or someone who can pick them up to help them engage? Is there child care available? Very often, sabotaging child care is a very subtle way to sabotage a survivor's access to treatment. And we child care is so hard to come by anyways.

And so I already mentioned that a common power and control tactic is to undermine a survivors relationship with their children, and yet research consistently shows that the most protective thing for children is attachment with that protective caregiver. That this is so protective of children's resilience and development. And so within our services, counteracting this form of abuse, and then actively supporting parent-child attachment with protective caregivers.

So here's just a visual. So many of the different tactics at play. And then anywhere we're stigma shows up in systems, including our own services, that is an entryway for this kind of abuse to come in and really harm survivors and their children. And so first and foremost, one of the most important things we need to do is look at the presence of stigma in all of our systems, in our communities in our own programs and practices, and really eradicate that stigma.

Now looking at alcohol use and abusive behavior. So very often, there is this misunderstanding that alcohol use somehow causes abusive behavior. And this is a really, really dangerous misunderstanding, because first of all, it delays the help that people who seek to cause harm against their intimate partners need. Really delays that help.

And then, of course, it perpetuates ongoing danger for survivors and their children and other family members, including pets. So what the research has

found is that there are high rates of alcohol use amongst people who abuse their intimate partners, but that that alcohol use does not cause domestic violence.

That when just the alcohol use has been addressed, that the domestic violence doesn't stop. That it actually tends to become more overt and in some ways more dangerous. So what alcohol use does do is that it increases the lethality of abuse. It increases the risk of homicide. And so in that way, that is the reason why a lot of times people think that alcohol use causes abusive behavior, because it's when they notice the domestic violence go from being covert to come to a crisis point, and then people say, oh, it caused the abuse. That's why there's that misperception.

So some things to keep in mind here is that sometimes within protective systems, within the legal systems, a decision is made to say, well, let's get the person treatment for their alcohol use disorder and not issue an order of protection. And that can really delay the safety measure that survivor is seeking in that moment and really increase that survivor's danger.

If a survivor is seeking an order of protection and then it's denied in favor of trying alcohol use disorder treatment first, that can really increase survivor's danger. And that we don't want siloed approaches to abusive behavior and alcohol use disorder. Now what's been found to be most effective is, just like many other co-occurring concerns, is integrated services and treatment.

So given the realities of alcohol use and domestic violence, how can we enhance safety and recovery for survivors within our services where many times in our services people may be accessing services in the same location where someone who has committed domestic violence is also accessing services? So how do we build safety?

So here, with just the few minutes that we have left, I'm going to be giving some really, really broad overall information and then pointing to different resources that are available completely for free through

our National Resource Center. So first, what I'm going to name, a lot of it is contained in this toolkit. Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence, A Toolkit for Screening, Assessment, and Brief Counseling in primary care and behavioral health settings.

So one thing that we want to first consider is, where are we in the continuum of responsiveness to the intersections of domestic violence and alcohol use?

And where do we want to be? So informed. Well first, there's uninformed where there's not a whole lot of information around these intersections, and so of course, policies and practices aren't informed by this.

But then getting on to the continuum of responsiveness, first is informed. So programs that are aware of these dynamics, including substance use coercion. Very common things that we'll see here are things like cross-training between alcohol use and domestic violence, more interdisciplinary teams, and more full partnerships with local domestic violence programs.

Then we'll see collaborative programs. So these are programs that have active collaborations across domestic violence and alcohol use disorder treatment fields. Here, sometimes we see co-facilitated groups in both settings, which can create a really seamless bridge where people don't have to self-identify a need before they start accessing some information, and then where they can start building relationship with a face, a name, someone that they can trust who then can form that bridge into that specialized service.

We'll also see active linkages and sometimes co-location. Or staff swapping, where a staff member might go and spend a morning at the other program once a week, things like that. And then integrated program where you see a full integration of these services, where they're integrated throughout. Assessment, service planning, and a menu of services is offered across programs and really based on a survivor's self-defined needs. We often think of this as a no wrong door approach as well.

So as you prepare your program or your practice, here are some fundamental steps. First, just universal training. Universal training on this. Cultivating programs that are accessible, culturally responsive, and trauma-informed. Centering survivor's self-defined goals and concerns. So if any of our programs are continuing to take top-down approaches rather than person-centered care, it's really important that we really adopt and cultivate person-centered care, because that is critical for the safety and accessibility of survivors.

Developing relationships with local domestic violence advocacy programs. Attending to safety and confidentiality throughout all of our processes, from pre-intake to the way that we're documenting to billing. So throughout all of our services. And then really having a culture of staff support and community care for the staff in our programs.

So here's a tip sheet that we have. It's called 7 Common Practices in Substance Use Disorder Care That Can Hurt Survivors and What You Can Do Instead. So this is one way to start thinking about, what are we already doing

that creates access and safety and effectiveness for survivors? And where can we grow? Where might we want to place some attention?

Now looking at key elements in clinical and peer support services, that we have routine opportunities for conversation about domestic violence that are safe conversations, that are person-centered conversations. That we validate and affirm survivors while recognizing the impact of abuse and trauma.

That we address immediate and ongoing safety needs and partner with survivors on safe strategies for mitigating domestic violence and substance use coercion. That we're able to actively link to local advocacy services when a person wants that, as well as actively link to-- or integrate attention to services that will help people who are causing harm to their intimate partner or have a history of causing harm.

And then, of course, treatment interventions that are evidence-based for survivors, as well as people who cause harm. I remember providing treatment, and many people, because they felt safe in the treatment environment, disclosing that they were struggling with causing harm and really wanting services around that. So we want to be prepared.

So here's one of our service-- one of our resources. It's a palm card on substance use coercion. That is like a SBIRT-style conversation guide. I think of it as a cheat sheet as we're getting used to having these conversations. And this is the front side and then this is the back side around that collaboration and safety planning and connecting to resources.

We also have different repositories on evidence-based care for survivors. Two that I'll highlight are Helping Women Recover, and there's also Helping Men Recover, as well as Seeking Safety. And that these five elements can be added to any evidence-based practice that you're already using in order to enhance its effectiveness for survivors.

We also have a toolkit that has a lot of different information, but one of the things that has is how to help survivors safely and meaningfully access community mutual aid recovery groups. And it's something that should never be mandated or pressured, but that we should really help survivors access if they're interested in it.

And then we-- as I mentioned earlier, offering multigenerational services. And so here we have a family-centered toolkit. And it was developed specifically for domestic violence programs, but we've heard from a lot of substance use

disorder treatment programs that they have started using it and that they have found it really, really helpful in adopting more family-based services.

And ultimately, to think about recovery capital and all the different ways that domestic violence directly interrupts access to recovery capital. And so mitigating the effects of the domestic violence as well as helping survivors to develop their own safety strategies. Survivors are the on what will increase their safety and what's possible for them in that moment. And that recovery capital is always important and becomes all the more important when somebody is experiencing domestic violence.

So with that, I'll say thank you, and hopefully I've left time for a question or two.

PRESENTER: Well, we don't have any-- let's see. I don't see any questions other than a couple that were administrative in nature. Let's see. Here we go. Byron asks, thank you just. One more thing, do you know of any free websites to assist in mental health, substance abuse recovery, and peer education? And how do we get-- someone else is also asking, how do we order the palm cards to use?

GABRIELA ZAPATA-ALMA: Yes. So our palm cards are available for download on our website. We don't actually have tangible copies at this time, but you can download different sizes so you can print it, however is most helpful for you. And then you could also-- so we print-- we made it so you could like have it on a clipboard or you could fold it in half once you've printed it.

And then the first question, websites-- could you repeat the first question? Websites around what?

PRESENTER: Sure. Websites to assist in mental health, substance abuse recovery, and peer education. It seems as though it's a really general question and maybe not geared toward domestic violence, but-- and I'm not sure if it's your area of expertise.

GABRIELA ZAPATA-ALMA: Yeah, absolutely. So I would-- so if it's around an intersection with domestic violence, sexual violence, I definitely recommend our website. And then if it's more general, than I would really recommend following up with the Great Lakes TTCs. They have so many amazing resources and I'm sure can share so many more.

PRESENTER: I totally agree with you there. We are past our time, and hopefully everyone was able to download the slides. We will post them again, and the next in our series is on June 7. And that would be the Impact of Alcohol Use on Individuals with Mental Illness. We've posted a couple of links in the chat where you can go ahead and register for that, but you can always reach out to any of the TTC networks through the Great Lakes and ask for more information.

Thank you so much, Gabriela, and the information was very, very helpful.

GABRIELA ZAPATA-ALMA: Thank you.

PRESENTER: Have a wonderful day, everyone.